# DEARBORN DENTAL
## CHANGE FORM

| **Check desired change in coverage:** | | **Campus / Hospital** | | |
|---|---|---|---|---|
| **Prior:** | **New:** | ____LSU System | ____LSU-Shrev | ____EK Long MC |
| | | ____LSU A&M | ____UNO | ____HP Long MC |
| ___Emp Only | ___Emp Only | ____LSU-Alex | ____HSC-Shrev | ____Lallie Kemp MC |
| ___Emp+Sp | ___Emp+Sp | ____LSU-Eunice | ____HSC-New Orl | ____Moss Reg MC |
| ___Emp+Ch | ___Emp+Ch | ____Law Center | ____HCSD Hqtrs | ____University MC |
| ___Family | ___Family | ____Pennington | ____Med Ctr of LA | ____Bogalusa MC |
| | | ____Ag. Center | ____Conway | |

_____ _____/_____/_____ _____
Last name First Middle Birth date LSU ID

_____ ____Male ____Female _____/_____/_____
Home Street Address Marriage Date

_____ ____Single ____Married ____No. of Eligible
City State Zip Code Dependents

(_____)_____ (_____)_____ _____ _____/_____/_____
Home Phone Work Phone Department Date of Hire

List all Dependents participating in the plan:

| Last Name | First | Relationship | Date of Birth | M=Male F=Female (circle) | A=Add D=Delete |
|---|---|---|---|---|---|
| | | | ___/___/___ | M F | A D |
| | | | ___/___/___ | M F | A D |
| | | | ___/___/___ | M F | A D |
| | | | ___/___/___ | M F | A D |
| | | | ___/___/___ | M F | A D |

Dependent(s) home address if different from employee:

_____
Name Street City State Zip Code

| Change due to: | | Date | | Date |
|---|---|---|---|---|
| | _____Marriage | _____/_____/_____ | ____Death | _____/_____/_____ |
| | _____Divorce | _____/_____/_____ | ____Not elig. | _____/_____/_____ |
| | _____Birth | _____/_____/_____ | ____Other | _____/_____/_____ |

I hereby authorize you to deduct from my pay for the above insurance coverage (if any required)

____Cancel my coverage

____/____/____Term Date

_____ ____/____/____
Employee Signature Date

**Office Use Only**

Coverage eff. ____/____/____

Change eff. ____/____/____

Total Prem. $_____

HR/Payroll Rep_____